IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

July 28, 2009

Teresa Carpenter
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

RE: Preferred Community Homes - Cornerstone, provider #13G056

Dear Ms. Carpenter:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Cornerstone, which was conducted on July 16, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 10, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August 10, 2009. If a request for informal dispute resolution is received after August 10, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional BMP - Behavior Management Program G-tube - Gastrostomy Tube HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record NOS - Not Otherwise Specified PT - Physical Therapist QMRP - Qualified Mental Retardation Professional RSC - Resident Service Coordinator	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Cornerstone with the facts, findings or other statements as alleged by the state agency dated July 16, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Cornerstone – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and staff interviews it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for the individuals residing at the facility. This failure had the potential to negatively impact 8 of 8 individuals (Individuals #1 - #8) residing at the facility. The findings include: 1. The governing body failed to provide sufficient	W 104	**W 104 483.410(a)(1) GOVERNING BODY** Refer to W 111 Refer to W 112 Refer to W 159 Refer to W 218 Refer to W 262 Refer to W 263 Refer to W 322	

RECEIVED
AUG 07 2009
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Carpenter | TITLE: Admin | (X6) DATE: 8-7-09 mw

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' records contained accurate information. The facility was previously cited at W111 during a complaint survey dated 6/11/04, and annual recertification surveys dated 7/1/05, 9/21/06, and 7/31/08. 2. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' confidentiality was protected. The facility was previously cited at W112 during a recertification survey dated 7/31/08. 3. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' services were sufficiently coordinated and monitored by the QMRP. The facility was previously cited at W159 during annual recertification surveys dated 9/21/06 and 7/31/08. 4. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' physical and occupational assessments were updated when their physical and health status changed. The facility was previously cited at W218 during a recertification survey dated 7/31/08. 5. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure HRC approval was obtained for restrictive interventions. The facility	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 2 was previously cited at W262 during a recertification survey dated 7/31/08. 6. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure guardian consent was obtained for restrictive interventions. The facility was previously cited at W263 during a recertification survey dated 7/31/08. 7. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure continued correction of past deficiencies related to ensuring preventative and general health services were provided to individuals. The facility was previously cited at W322 during annual recertification surveys dated 7/1/05, 9/21/06, and 7/31/08.	W 104		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 3 of 4 individuals (Individuals #1 and #4) whose records were reviewed. This resulted in insufficient information being maintained for individuals. Findings include: 1. Individual #4's IPP, dated 2/24/09, documented	W 111	**W 111 483.410(c)(1)** **Client Records** The facility will develop and maintain a recordkeeping system that will document the clients health care, active treatment social information, and protection of there rights. Individual #4 will will have an updated Nutritional Assessment to reflect the current food/allergies. His IPP has been changed to reflect increased supervision, instead of one-on-one staffing. Individual #1 Baclofen pump has been added to his quarterly Physicians Order. #1 PT Evaluation has been re-done, service objective's have been revised. quarterly reviews will be conducted to ensure the deficient will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 3 a 14 year old male who was admitted to the facility on 1/28/09. His diagnoses included autism and severe mental retardation. a. Individual #4's Initial Nutritional Assessment, undated, listed wheat and cheese as "Food Allergies/Intolerances." However, during an observation on 7/13/09 from 5:01 - 5:46 p.m., Individual #4 was observed to be eating tamale pie casserole. When asked, staff stated the tamale pie casserole contained cheese. The Administrator, who was present during the observation, produced a document stating wheat and cheese were not food allergies, but part of a diet for autistic people which Individual #4 was on prior to his admission. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m. the Administrator stated Individual #4's Nutritional Assessment was not accurate. The facility failed to ensure Individual #4's record contained an accurate nutritional assessment. b. Individual #4's IPP, dated 2/24/09, documented he received one to one staffing. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m. if there were consents for one to one staffing, the Administrator stated his IPP was not accurate and it should have read "Increased Supervision." The facility failed to ensure Individual #4's IPP was accurate and reflected his current level of supervision.	W 111	#4. Refer to W 218 #5 Refer to W 220 #6 Refer to W 227 #7 Refer to W 260 To be completed by the QMRP, AQMRP, LPN, RN, and Administrator. By the 09/16/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 4 3. Individual #1's IPP, dated 12/30/08, documented a 35 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, left hip dislocation, left wrist fusion, severe kyphosis, cortical blindness, and status post left femur fracture. a. Individual #1's Neurology report, dated 3/25/09, documented he had an intrathecal Baclofen pump for his spasticity. However, his quarterly Physician's Order, dated 5/09 and developed by the facility, did not include Baclofen in his list of medications. When asked, the LPN stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., it was an oversight and his quarterly Physician's Order was not accurate. b. Individual #1's IPP stated a Hoyer lift was to be used for transfers at the facility. However, his Physical Therapy Evaluation, dated 1/5/09, stated the lift was to be used for all transfers. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the Physical Therapy Evaluation was not accurate and needed to be updated. c. Individual #1's IPP included a service objective to receive quarterly observations from the Social Worker. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the objective was not accurate and should have read annual, not quarterly. The QMRP stated Individual #1's IPP was not accurate and needed to be revised. 4. Refer to W218 as it relates to the facility's failure to ensure individual's physical and occupational assessments accurately reflected their physical and health status.	W 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 5 5. Refer to W220 as it relates to the facility's failure to ensure individual's speech language assessments accurately reflected their physical and health status. 6. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs were revised to included objectives to meet their needs. 7. Refer to W260 as it relates to the facility's failure to ensure individuals' IPPs were accurate and updated when necessary.	W 111		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all information was kept confidential for 4 of 4 individuals (Individuals #1, #3, #5 and #6) who received services at the facility's off site day treatment program. This resulted in individuals' information being available to visitors at the off site day treatment facility. The findings include: 1. Individuals #1, #3, #5 and #6 attended an off site day treatment program with public access. During an observation on 7/14/09 from 10:45 - 11:41 a.m. at the facility's off site day treatment program, two older people (non-staff) were noted to be sitting next to the treatment area. When asked about the older couple, a staff stated the couple was there to see the Veteran's	W 112	**W 112 483.410(c)(2) CLIENT RECORDS** The facility will put cubicals up at the Day Treatment Day center to provide privacy for all clients that receive services there. The cubicals will be at the Center to ensure that the deficient will not recur. To be completed by the RSC, and The Administrator by 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 112	Continued From page 6 Administration Representative. The staff further stated it was "typical" to have people come in and "it's business." Additionally, two more people (non-staff) came in the treatment area during the observation. Further, a staff working with Individuals #1 and #3 was noted to periodically address them by their first and last name. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the Administrator stated all individuals' right to confidentiality should be protected. The facility failed to maintain confidentiality for Individuals #1, #3, #5 and #6. Repeat Deficiency.	W 112		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided privacy during treatment and care of personal needs for 4 of 4 individuals (Individuals #1, #3, #5 and #6) who received services at the facility's off site day treatment program. This resulted in individuals receiving physical therapy treatments without privacy. The findings include: 1. Individuals #1, #3, #5 and #6 attended an off site day treatment program with public access.	W 130	**W 130 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS** Refer to W 112.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 7 During an observation on 7/15/09 from 9:05 - 9:47 a.m., Individuals #1, #3, #5 and #6 were noted to receive physical therapy treatment on large floor mats in an open area inside the main entrance to the building. A man, not associated with the facility, was present during the observation. When asked, the man stated he was there 3 times per week to do secretary work and that he came in at approximately 9:00 a.m. to check the mail. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the Administrator stated all individuals' right to privacy should not be violated. The facility failed to ensure Individuals #1, #3, #5 and #6's privacy was protected during physical therapy treatments.	W 130		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination for 7 of 8 individuals (Individuals #1 - #7) residing at the facility. That failure resulted in individuals not receiving the necessary services, supports, and training required to meet their physical and health needs. The findings include: 1. Refer to W111 as it relates to the facility's	W 159	**W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL** In order to ensure that the QMRP provides sufficient monitoring and coordination of the status of the Cornerstone Clients, and to ensure that the individuals receive the necessary services, supports and training to meet their health, safety, and behavioral needs. The plan of correction for the following Federal listed under W 159 will serve as the plan of correction to ensure individuals residing at Cornerstone will receive services and required training to meet their development and behavioral needs. In addition the QMRP is receiving additional training to ensure that W159 will not recur, and disciplinary action will be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 8 failure to ensure the QMRP ensured individuals' records contained accurate information. 2. Refer to W112 as it relates to the facility's failure to ensure the QMRP ensured individuals' confidentiality was protected. 3. Refer to W130 as it relates to the facility's failure to ensure the QMRP ensured individuals' right to the privacy was not violated during treatment. 4. Refer to W218 as it relates to the facility's failure to ensure the QMRP ensured individuals' physical therapy and occupational therapy assessments were updated as needed. 5. Refer to W220 as it relates to the facility's failure to ensure the QMRP ensured individuals' speech language assessments were updated as needed. 6. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured objectives were developed to meet individuals' needs. 7. Refer to W231 as it relates to the facility's failure to ensure the QMRP ensured individuals' objectives contained measurable indices of performance. 8. Refer to W260 as it relates to the facility's failure to ensure the QMRP ensured individuals' IPPs were revised as necessary. 9. Refer to W262 as it relates to the facility's failure to ensure the QMRP ensured HRC approval was received prior to implementing restrictive interventions.	W 159	Please refer to W111, W112,W130 W218, W220, W227, W231, W260, W262, W263, W322, W382, W436, and W488 for specific information relating to those deficiencies. To be completed by the QMRP, AQMRP, Behavioral Specialist, and Administrator by 09/28/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 9 10. Refer to W263 as it relates to the facility's failure to ensure the QMRP ensured parent/guardian approval was received prior to implementing restrictive interventions. 11. Refer to W322 as it relates to the facility's failure to ensure the QMRP ensured individuals received general and preventative care. 12. Refer to W382 as it relates to the facility's failure to ensure the QMRP ensured all drugs and biologicals were locked. 13. Refer to W436 as it relates to the facility's failure to ensure the QMRP ensured individuals using wheelchairs had current wheelchair evaluations. 14. Refer to W488 as it relates to the facility's failure to ensure the QMRP ensured individuals ate in a manner consistent with their developmental levels. The cumulative effect of these negative facility practices significantly impeded the ability of the facility to provide services to meet the health, safety, and physical needs of individuals residing in the facility. Repeat deficiency.	W 159		
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it	W 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 218	Continued From page 10 was determined the facility failed to ensure the sensorimotor assessments were updated as recommended and as needed for 3 of 7 individuals (Individuals #1 - #3) whose sensorimotor assessments were reviewed. This resulted in a lack of follow-up for an individual and individuals' assessments not being an accurate reflection of their current health status. The findings include: 1. Individual #1's IPP, dated 12/30/08, documented a 35 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, left hip dislocation, left wrist fusion, severe kyphosis, cortical blindness, and status post left femur fracture. Individual #1's medical record contained a bone densitometry report, dated 2/20/09, which documented he had osteopenia and was at a moderately high risk for fractures. It was not evident that his Physical Therapy Evaluation, dated 1/5/09, and his Occupational Therapy Evaluation, dated 6/26/08, had been updated given his increased risk for fractures. When asked, the Administrator stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the Evaluations were not updated and that Individual #1 had a bone densitometry test performed in 2006. However, Individual #1's bone densitometry report, dated 4/25/06, stated the test was limited to the spine area only and showed Individual #1 was considered at a moderately low risk for fractures at that time.	W 218	**W 218 483.440(c)(3)(v)** **INDIVIDUAL PROGRAM PLAN** Individual's 1, 2, 3, will have updated OT and PT evaluations to evaluate the current needs and current status of the clients. the functional assessment will be re-assessed to include all of the pertinent information, all the information will be specific. this will be done for all clients at Cornerstone to ensure the deficient will not recur. To be completed by the QMRP, AQMRP, and the Administrator By 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 218	Continued From page 11 The facility failed to ensure Individual #1 Physical Therapy and Occupational Therapy Evaluations were updated when his and physical status changed. 2. Individual #2's IPP, dated 9/24/08, documented a 17 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, status post left femoral fracture, bilateral hip dysplasia, dysphasia, and cortical blindness. Individual #2's Nurse's Notes, dated 2/26/09, stated "Staff and QMRP concerned R (right) hip not looking normal." His Nurse's Notes, dated 2/28/09, documented that on 2/26/09, Individual #2 was taken to a nearby hospital for x-rays. The diagnostic imaging report, dated 2/26/09, showed "There is osteopenia...There is right acetabular dysplasia with what appears to be congenital dislocation of the right hip. This has progressed when compared to images of the pelvis performed 12/28/06." It was not evident Individual #2's Physical Therapy Evaluation, dated 6/4/08, and his Occupational Therapy Evaluation, dated 1/14/08, had been updated given his osteopenia and condition of his right hip. Further, Individual #2's IPP stated bilateral hand splints were used to prevent increased deformity to his hands. His IPP stated the splints were worn 2 hours on, 1 hour off during waking hours. However, his Physical Therapy Evaluation, dated 6/4/08, stated the splints were only worn at night or when he was in bed and his Occupational Therapy Evaluation, dated 1/14/08, stated the	W 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 218	Continued From page 12 splints were discontinued. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., Individual #2 had hand splints that were only worn for two hours each evening. When asked, the Administrator, who was present during the interview, stated Individual #2's evaluations had not been updated. The facility failed to ensure Individual #2's Physical Therapy and Occupational Therapy Evaluations were updated when his health and physical status changed. 3. Individual #3's IPP, dated 3/13/09, documented a 34 year old female whose diagnoses included profound mental retardation, hydrocephalus, and seizure disorder. Review of Individual #3's Physical Therapy Evaluation, dated 10/23/08, documented "[Individual #3] will participate in her home exercise program each day and will be reviewed by PT at least every 6 months." When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the LPN stated Individual #3 had not been reviewed by the Physical Therapist since 10/23/08. The facility failed to ensure Individual #3 received a physical therapy review as recommended by the Physical Therapist. Repeat Deficiency.	W 218		
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 220	Continued From page 13 include speech and language development. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the speech and language assessment was updated as needed for 1 of 1 individual (Individual #2) observed to use a gastrostomy tube. This resulted in an individual's speech language assessment not being an accurate reflection of his current health status. The findings include: 1. Individual #2's IPP, dated 9/24/08, documented a 17 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, status post left femoral fracture, bilateral hip dysplasia, dysphasia, and cortical blindness. During the entrance conference on 7/13/09 at 9:15 a.m., the Administrator informed the survey team that Individual #2 used a G-tube for nutrition and medication administration. This was confirmed during medication pass on the afternoon of 7/13/09 at 4:11 p.m. and medication pass on the morning of 7/14/09 at 6:15 a.m. Individual #2's Nurse's Notes, dated 6/10/09, documented that during a swallowing evaluation on that day, it was noted that Individual #2 was no longer able to chew and swallow. The 6/10/09 Nurse's Notes documented he was to receive all nutrition and medications via his G-tube. However, his Speech Language Evaluation, dated 9/8/08, stated his feeding and swallowing skills were not formally assessed but "He is apparently	W 220	**W 220 483.440(c)(3)(v)** **INDIVIDUAL PROGRAM PLAN** The CFA will include speech and language development. Individual #2 received a current speech and language evaluation on 07/17/09. When any substantial change has been made with any client living at Cornerstone, up-dated evaluations will be completed, as well as an up-dated CFA. This will be done to ensure the deficient will not recur. To be completed by the LPN, QMRP, and the Administrator By 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 220	Continued From page 14 on a diet of pureed and pudding thick foods and liquids." It was not evident his Speech Language Evaluation had been updated given his inability to chew and swallow. When asked, the Administrator stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the Evaluation was not updated. The facility failed to ensure Individual #2's Speech Language Evaluation was updated when his health and physical status changed.	W 220		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure the IPP included objectives to meet the needs for 3 of 5 individuals (Individuals #2, #3, and #7) whose IPPs, objectives, and assessments were reviewed. This resulted in individuals participating in programming without corresponding objectives to meet their physical needs. The findings include: 1. Individual #2's IPP, dated 9/24/08, documented a 17 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, status post left femoral fracture, bilateral hip dysplasia, dysphasia, and cortical blindness.	W 227	**W 227 483.440(c)(4)** **INDIVIDUAL PROGRAM PLAN** Individual's 2, 3, and 7, have been re-assessed by the PT. the IPP will be up-dated to reflect the assessments recommendations, whenever an assessment is up-dated or re-done, the IPP will also be up-dated, to reflect the recommendations. This will be done for all clients living at Cornerstone to ensure the deficient will not recur. To be completed by the QMRP, AQMRP, and the Administrator by 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 15 Individual #2's Physical Therapy Evaluation, dated 6/4/08, included recommendations for tailor sitting on a large wedge facing downward, to encourage head lifting, trunk rotation stretches, shoulder flexion, and prone and supine positioning on a physioball. Individual #2's IPP did not contain objectives related to the physical therapy recommendations. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., there were no objectives developed for Individual #2's physical therapy exercises but there were programs in place. The facility failed to ensure objectives related to Individual #2's physical needs were developed and incorporated in his IPP. 2. Individual #3's IPP, dated 3/13/09, documented a 34 year old female whose diagnoses included profound mental retardation, hydrocephalus, and seizure disorder. During an observation at the facility's day treatment program on 7/15/09 from 9:05 - 9:47 a.m., Individual #3 was observed to be in a long sitting position. However, her IPP did not contain a related objective. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the QMRP stated Individual #3 did not have an objective for long sitting in her IPP and it was an oversight on his part. The facility failed to ensure Individual #3's IPP contained all objectives necessary to address her	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 16 current needs. 3. Individual #7 Pediatric Physical Therapy Examination, dated 5/8/09, documented a 14 year old male whose diagnosis included profound mental retardation and seizure disorder. The Evaluation section of the report recommended using a physioball for trunk control and weight bearing activities for his upper extremities. However, his IPP contained no objectives related to the recommendations. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the QMRP stated there were no objectives for the physioball or upper extremity weight bearing. The QMRP stated Individual #7's IPP needed revised. The facility failed to ensure Individual #7's physical therapy recommendations were incorporated in his IPP.	W 227		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the objectives of the IPP were behaviorally stated in measurable terms so as to accurately monitor progress towards the objectives for 4 of 4 individuals (Individuals #1 - #4) whose IPPs and program objectives were reviewed. This resulted in individuals participating in activities for which progress and regression could not be assessed.	W 231	**W 231 483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN** To avoid deficiencies like the one described, the facility will review the wording of the objectives and determine other approaches to take to monitor progress or regression towards objective goals, which may include changing the word of the actual objectives. For all Cornerstone clients this has corrected as of 08/05/09. Review of all clients Q books will be done quarterly to ensure the deficient does not recur. To be completed by the QMRP, AQMRP, and Administrator by 08/05/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 231	Continued From page 17 The findings include: 1. Individual #1's IPP, dated 12/30/08, documented a 35 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, left hip dislocation, left wrist fusion, severe kyphosis, cortical blindness, and status post left femur fracture. His IPP included a list of formal objectives which were not expressed in behaviorally stated, measurable terms. Examples include, but are not limited to, the following: a. "[Individual #1] will independently complete one swipe with the dishcloth 85% of the trials for six consecutive months." It was not clear if the criteria was 85% each month for 6 consecutive months or if it was 85% of all trials for 6 consecutive months. b. "[Individual #1] will remain continent 70% of the trials for six consecutive months." It was not clear if the criteria was 70% each month for 6 consecutive months or if it was 70% of all trials for 6 consecutive months. c. "[Individual #1] will independently shave his face for 15 seconds with two verbal prompts or less 70% of trials." It was not clear if the criteria was 70% each month and the number of consecutive months was not specified. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the intent was to obtain the percentage on a monthly basis, and then uphold that percentage for 6 consecutive months.	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 231	Continued From page 18 2. Individual #2's IPP, dated 9/24/08, documented a 17 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, status post left femoral fracture, bilateral hip dysplasia, dysphasia, and cortical blindness. a. "[Individual #2] will tolerate hand over hand assistance to brush his teeth for 60 seconds 95% of trials for six consecutive months." It was not clear if the criteria was 95% each month for 6 consecutive months or if it was 95% of all trials for 6 consecutive months. b. "[Individual #2] will remain continent 65% of the trials for six consecutive months." It was not clear if the criteria was 65% each month for 6 consecutive months or if it was 65% of all trials for 6 consecutive months. c. "[Individual #2] will tolerate assistance to put on his shirt, with hand over hand assistance 75% of trials for six consecutive months." It was not clear if the criteria was 75% each month for 6 consecutive months or if it was 75% of all trials for 6 consecutive months. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the intent was to obtain the percentage on a monthly basis, and then uphold that percentage for 6 consecutive months. 3. Individual #3's IPP, dated 3/13/09, documented a 34 year old female whose diagnoses included profound mental retardation, hydrocephalus, and seizure disorder. Her IPP included a list of formal objectives which	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 231	Continued From page 19 were not expressed in behaviorally stated, measurable terms. Examples include, but are not limited to, the following: a. "[Individual #3] will independently hold her glass while drinking 50% of trials for six consecutive months." It was not clear if the criteria was 50% each month for 6 consecutive months or if it was 50% of all trials for 6 consecutive months. b. "[Individual #3] will wipe her spot at the table with assistance at the elbow 80% of trials for six consecutive months." It was not clear if the criteria was 80% each month for 6 consecutive months or if it was 80% of all trials for 6 consecutive months. c. "[Individual #3] will, with assistance, brush her hair for 20 seconds 75% of trials for six consecutive months." It was not clear if the criteria was 75% each month for 6 consecutive months or if it was 75% of all trials for 6 consecutive months. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the intent was to obtain the percentage on a monthly basis, and then uphold that percentage for 6 consecutive months. 4. Individual #4's IPP, dated 2/24/09, documented a 14 year old male whose diagnoses included autism and severe mental retardation. His IPP included a list of formal objectives which were not expressed in behaviorally stated, measurable terms. Examples include, but are not limited to, the following:	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 231	Continued From page 20 a. "[Individual #4] will stand on one leg with support for 10 seconds, with hand over hand assistance, 90% of the trials for 3 consecutive months." It was not clear if the criteria was 90% each month for 3 consecutive months or if it was 90% of all trials for 3 consecutive months. b. "[Individual #4] will put on deodorant with hand over hand assistant [sic], 95% of the trials for 3 consecutive months." It was not clear if the criteria was 95% each month for 3 consecutive months or if it was 95% of all trials for 3 consecutive months. c. "[Individual #4] will stand on his tip toes and reach for an object 10 times with hand over hand assistance, 25% of the trials for 3 consecutive months." It was not clear if the criteria was 25% each month for 3 consecutive months or if it was 25% of all trials for 3 consecutive months. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the intent was to obtain the percentage on a monthly basis, and then uphold that percentage for 3 consecutive months. The facility failed to ensure Individuals #1 - #4's objectives were stated in measurable terms.	W 231		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by:	W 260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 22 documented Individual #2 was to receive all nutrition and medications via his G-tube. However, Individual #2's IPP stated he received a pureed diet with pudding thick liquids. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., Individual #2's IPP needed to be revised. The facility failed to ensure Individual #2's IPP was revised to reflect his current needs and health status. 2. Individual #1's IPP, dated 12/30/08, documented a 35 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, left hip dislocation, left wrist fusion, severe kyphosis, cortical blindness, and status post left femur fracture. a. Individual #1's Speech Language Evaluation, dated 6/11/09, included recommendations for him to verbalize leisure choices and name his body parts. It was not evident the recommendations were incorporated into Individual #1's IPP. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the recommendations were not incorporated into Individual #1's IPP and his IPP needed to be revised. b. Individual #1's IPP stated a Hoyer lift was to be used for transfers at the facility. However, his programs related to his physical therapy exercises, dated 2/09, showed the lift was to be used for all transfers.	W 260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 21 Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals' IPPs accurately reflected and responded to the individuals' needs for 4 of 5 individuals (Individuals #1 - #3 and #7) whose IPPs, objectives, and assessments were reviewed. This resulted in individuals' IPPs not being revised to reflect their current needs and status. The findings include: 1. Individual #2's IPP, dated 9/24/08, documented a 17 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, status post left femoral fracture, bilateral hip dysplasia, dysphasia, and cortical blindness. a. Individual #2's IPP stated bilateral hand splints were used to prevent increased deformity to his hands. His IPP stated the splints were worn 2 hours on, 1 hour off during waking hours. However, Individual #2's Physical Therapy Evaluation, dated 6/4/08, stated the splints were only worn at night or when he was in bed. Further, his Occupational Therapy Evaluation, dated 1/14/08, stated the splints were discontinued. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., Individual #2 had hand splints that were only worn for two hours each evening and his IPP needed to be revised. b. Individual #2's Nurse's Notes, dated 6/10/09, documented that during a swallowing evaluation on that day, it was noted he was no longer able to chew and swallow. The 6/10/09 Nurse's Notes	W 260	**W 260 483.440(f0(2) PROGRAM MONITORING & CHANGE** Individuals 1, 2, and 7 will have updated IPP's that reflect and respond to there individual needs. #2 will be re-assessed for his hand splints, his IPP will be revised for his current needs. #1 IPP will be revised to meet and reflect his current needs, as well as his assessments. All IPP's will be revised to reflect the clients current needs, Quarterly reviews will be done to ensure the deficient does not recur. To be completed by the QMRP, and AQMRP, and the Administrator. By 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 23 When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the programs needed to be updated. c. Individual #1's IPP included a service objective to receive quarterly observations from the Social Worker. When asked, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., the objective was not accurate and should have read annual, not quarterly. The QMRP stated Individual #1's IPP needed to be revised. The facility failed to ensure Individual #1's IPP was revised to reflect his current needs and status. 2. Refer to W227 as it relates to the facility's failure to ensure objectives were developed to meet individuals' needs.	W 260		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 2 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individuals' rights through	W 262	**W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** All cornerstone clients on any restrictive programs, will have all components added to their consents. All restrictive programs will be taken before the parents, legal guardians, and the HRC committee. This will happen before the restriction occurs. all Cornerstone clients will be reviewed quarterly by the HRC to ensure that the deficient will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 262	Continued From page 24 prior approvals of restrictive interventions. The findings include: 1. Individual #3's IPP, dated 3/13/09, documented a 34 year old female whose diagnoses included profound mental retardation, hydrocephalus, and seizure disorder. Review of her Supplemental or Treatment Notes documented Individual #3 was physically restrained during dental procedures on 10/16/08 and 4/20/09. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the Administrator stated Individual #3 did not have HRC approval for the dental restraints. The facility failed to ensure HRC approval for Individual #3's restrictive interventions was obtained prior to their use.	W 262	To be completed by the QMRP, AQMRP, and the Administrator by 09/16/09.	
W 263	Repeat deficiency. 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 2 individual (Individual #3) whose restrictive interventions were reviewed. This resulted in a	W 263	**W 263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE** All clients that have restrictive components to them, will have prior consent given by HRC, parents, and/or legal guardians. restrictive programs will be reviewed by a checklist monitoring the Q books quarterly to ensure that the deficient will not recur. To be completed by the QMRP, AQMRP, and the Administrator By 09/16/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 25 lack of protection of an individual's rights through prior approvals for restrictive interventions. The findings include: 1. Individual #3's IPP, dated 3/13/09, documented a 34 year old female whose diagnoses included profound mental retardation, hydrocephalus, and seizure disorder. Review of her Supplemental or Treatment Notes documented Individual #3 was physically restrained during dental procedures on 10/16/08 and 4/20/09. When asked during an interview on 7/16/09 from 10:00 a.m. - 12:35 p.m., the Administrator stated Individual #3 did not have parent/guardian approval for the dental restraints. The facility failed to ensure parent/guardian approval for Individual #3's restrictive interventions was obtained prior to their use. Repeat deficiency.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure adequate general and preventative medical care was provided to 4 of 5 individuals (Individuals #2, #3, #5 and #6) whose used wheelchairs for mobility purposes. This resulted in the potential for individuals health needs to not be met. The	W 322	**W 322 483.460(a)(3)** **PHYSICIAN SERVICES** The facility will provide preventive and general medical care for all clients living at Cornerstone. Individual 2, 3, 5, and 6 have received Dexoscan's on 08/06/09. All clients residing at Cornerstone that are in wheelchairs will have an initial Dexoscan and a repeat as Dr. recommends. This will ensure that the deficient will not recur. To be completed by the LPN, RN, and Administrator by 08/06/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 26 findings include: 1. According to the Internet website, www.WebMD, the risk factors of osteopenia (bone mineral density [BMD] that is lower than normal peak BMD but not low enough to be classified as osteoporosis) were risks for men as well as women. According to WebMD, risk factors include being thin, long term use of anticonvulsants for pain or seizures, eating disorders, and being inactive for a long period of time. Additionally, according to the Internet website, www.osteopenia, "...activity is so important that even several weeks of bed rest or the use of a wheel chair can lead to serious bone loss." a. Individual #2's IPP, dated 9/24/08, documented a 17 year old male diagnosed with profound mental retardation, seizure disorder, scoliosis, spastic quadriplegia, status post left femoral fracture, bilateral hip dysplasia, dysphasia, and cortical blindness. He used a wheelchair for mobility and ambulation purposes. His IPP stated he required two persons for transfers and his medical record showed he routinely received Zonegran (an anticonvulsant drug) for seizure control. b. Individual #3's IPP, dated 3/13/09, documented a 34 year old female whose diagnoses included profound mental retardation, hydrocephalus, and seizure disorder. Her medical record documented that she used a wheelchair for mobility and ambulation purposes and routinely received Depakote, Tegretol, and Topamax (anticonvulsant drugs) for seizure control.	W 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 27 c. Individual #5's IPP, dated 3/13/09, documented a 34 year old male diagnosed with profound mental retardation, seizure disorder, kyphoscoliosis, quadriplegia with profound flexion contractures of both upper and lower extremities, bilateral proximal femoral resection, and bilateral hip dislocation. His IPP stated he used a wheelchair for mobility and ambulation purposes and required a Hoyer lift or two persons for transfers. d. Individual #6's IPP, dated 4/2/09, documented a 33 year old male diagnosed with profound mental retardation, spastic quadriplegia, dislocated left hip, cortical blindness, and anorexia. His IPP stated he was to receive large or double portions, seconds of his favorite food, and Carnation Instant Breakfast three times a day. His IPP stated his ideal weight range was 139 to 169 pounds and his current weight was 125 pounds. His IPP stated he used a wheelchair for mobility and ambulation purposes and required moderate to maximal assistance with all functional transfers and maximal assistance to maintain a standing position. When asked about bone densitometry tests for Individuals #2, #3, #5 and #6, the LPN stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., she had not thought of it. The facility failed to ensure bone densitometry tests were pursued for Individuals #2, #3, #5 and #6 who were at risk for osteopenia and osteoporosis. Repeat Deficiency.	W 322		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING	W 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 382	Continued From page 28 The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs were maintained under locked conditions for 2 of 8 individuals (Individuals #1 and #7) residing in the facility. This resulted in the potential for harm in the event the individuals accessed and ingested medications. The findings include: 1. An environmental review was conducted at the facility on 7/16/09 from 8:33 - 9:12 a.m. During that time, it was noted that Individual #1's hygiene box, located in an unlocked cabinet in the bathroom, contained Clindamycin 1%, a topical medication used to treat acne. The RSC, who was present during the review, was notified of the unlocked medication. The RSC took the prescription medication and locked it inside the medication cabinet. Individual #7's hygiene box, located in an unlocked cabinet in the second bathroom, contained Clindamycin 1%, a topical medication used to treat acne. The RSC, who was present during the review, was notified of the unlocked medication. The RSC took the prescription medication and locked it inside the medication cabinet as well. When asked, the LPN stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., all medications were to be kept locked when not in use.	W 382	**W 382 483.460(l)(2)** **DRUG STORAGE & AND RECORDKEEPING** Individual 1, and 7 have had the meds removed from there hygiene boxes. All hygiene boxes will be monitored weekly by the LPN, and monthly by the RSC, to ensure that this deficient will not recur. To be completed by the LPN, and RSC by 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 382	Continued From page 29 The facility failed to ensure all medications were kept locked when not in use.	W 382		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure individuals' adaptive equipment was periodically assessed and kept in good repair for 3 of 5 individuals (Individuals #3, #5, and #6) who required adaptive equipment for mobility. This resulted in an individual's wheelchair being in disrepair and inappropriate seating for individuals. The findings include: 1. During observations conducted on 7/13/09 and 7/14/09 for a cumulative 5 hours 28 minutes, Individuals #3, #5, and #6 were noted to be sitting in their wheelchairs and the end of the seats of their wheelchairs were no less than 6 inches from the bend of their knees, as follows: - Individual #3: The left arm rest of her wheelchair was torn. - Individual #5: The seat of his wheelchair was 7 inches from the bend of his knees. His IPP stated he obtained his current chair in 2005.	W 436	**W 436 483.470(g)(2)** **SPACE AND EQUIPMENT** The facility will ensure that individuals residing at Cornerstone will have wheelchair evaluations and that the chairs will be in good repair and proper fit. #3 arm pad will be replaced, #3 and #6 had wheelchair evaluations done on 07/31/09. monthly wheelchair inspections will be done to ensure the deficient will not recur. To be completed by the QMRP By 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 30 - Individual #6: The seat of his wheelchair was 6 inches from the bend of his knees. He was noted to continually sit with his body turned to the right. His IPP did not contain information related to positioning concerns or when the chair was obtained. When asked about wheelchair evaluations, the QMRP stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., no evaluations had been completed. The facility failed to ensure individuals' wheelchairs were evaluated for proper fit and kept in good repair.	W 436		
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure each individual ate in a manner consistent with their developmental level for 3 of 7 individuals (Individuals #4, #5, and #6) observed during a morning meal. This resulted in individuals not gaining independence that would further assist them to live in less restrictive environments. The findings include: 1. An observation was conducted at the facility on 7/14/09 from 6:10 - 8:20 a.m. Breakfast was served at 7:58 a.m., with the following concerns: The breakfast meal consisted of Malt-O-Meal which appeared to be watery/runny, strips of	W 488	**W 488 483.480(d)(4)** **DINING AREA AND SERVICES** Individuals 4, 5, and 6 will be given divided plates, or separate plates, so that there meal will not be mixed all together. All staff will be in-serviced quarterly on training issue's related to dining, including but not limited to pouring, serving, and cutting, this will be done for all clients residing at Cornerstone to ensure the deficient does not recur. Two tables or one long one will be purchased so that staff can be seated by the clients to model appropriate mealtime behavior and conversation to promote socialization and independence. To be completed by the QMRP, AQMRP, RSC, and the Administrator by 09/16/09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 488	Continued From page 31 bacon, toast, and sliced bananas. Staff were noted to place servings of the cereal, toast and banana in individuals non-divided scoop dishes and use rocker knives to cut the food into smaller pieces. Further, staff were noted to stand near the individuals during the meal. - Individual #4: He attempted to eat his cereal with a fork. When asked, the RSC, who was present during the observation, stated he would not use a spoon. However, staff were not noted to offer or encourage him to use a spoon. - Individual #5: He was noted to be transferred from his wheelchair to a standard dining chair that did not have side arms. He proceeded to rock side to side and a staff was noted to stand next to him and steady him. When asked about a chair with side arms, the RSC, who was present during the observation, stated they (the facility) did not have a chair with arms so staff "usually stands by him." - Individual #6: A staff added strips of bacon to his cereal. He attempted to eat the bacon strips with his spoon but they kept falling off, back into his cereal. A staff person was noted to assist him to cut his bacon into bite size pieces at 8:12 a.m. The RSC, who was present during the observation, was asked about staff sitting with individuals during the meal. The RSC stated "they never have." When asked, the Administrator stated during an interview on 7/16/09 from 10:35 a.m. - 12:45 p.m., they had never done family style dining. The facility failed to ensure meals were served in a family style manner such that individuals' food	W 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 488	Continued From page 32 items were kept separated as appropriate, individuals were encouraged or assisted to serve themselves, and that staff were able to model appropriate mealtime behavior and conversation to promote socialization and independence by sitting at the table with them.	W 488		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 16.03.11.075.10(a) Approval of Human Rights Committee. Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 16.03.11.075.10(c) Consent of Parent or Guardian Refer to W263	
MM199	16.03.11.075.11 Assurance of Confidentiality Assurance of Confidentiality. Each resident admitted to the facility must be assured confidential treatment of his personal and medical records, and must be permitted to approve or refuse their release to any individual outside the facility except: This Rule is not met as evidenced by: Refer to W112.	MM199	MM199 16.03.11.075.11 Assurance of Confidentiality Refer to W112	
MM203	16.03.11.075.12(a) Treated with Consideration Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W130.	MM203	MM203 16.03.11.075.12(a) Treated with Consideration Refer to W310	

RECEIVED
AUG 07 2009
FACILITY STANDARDS

Bureau of Facility Standards

Teresa Carpenter — TITLE Admin — (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER‹	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 1	MM380	MM380 16.03.11.120.03(a) Building and Equipment	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: An environmental survey was conducted on 716/09 from 8:30 - 9:12 a.m., and the following concerns were noted: - The floor strip between the living room and dining room was loose and created a trip hazard. - There was 1½ foot area in front of the shower that was missing caulking. The remaining caulking in front of the shower contained a build up of brown matter. - The foam toilet seat in the bathroom contained a 1½ inch tear. - Individual #6's comforter contained a 9 inch tear. - The sewer clean-out plug, located outside the facility, was broken.	MM380	The building and all equipment will be in good repair. The dining room floors will be replaced on 08/17/09 The caulking in the front shower has been replaced and the brown matter cleaned. The foam toilet seat in the back bathroom has been replaced. Individual #6 comforter has been thrown away and replaced. The sewer clean-out plug, Has been replaced.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM429	Continued From page 2	MM429	MM429 16.03.11.120.11 Equipment and Implementing polices	
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	Refer to W436	
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W104.	MM520	MM520 16.03.11.200.03(a) Establishing and implementing Policies Refer to W104	
MM570	16.03.11.210.05(b) Meidcations and Treatments A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W111.	MM570	MM570 16.03.11.210.05(b) Medications and Treatments Refer to W111	
MM660	16.03.11.250.05 General Diets The general menu must provide for the food and nutritional needs of the resident in accordance with the Recommended Daily Allowances of the Food and Nutritional Board of the National Academy of Service. A daily guide must be based	MM660	MM660 16.03.11.250.05 General Diets Refer to W488	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM660	Continued From page 3 on the following allowances: This Rule is not met as evidenced by: Refer to W488.	MM660		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	MM725 16.03.11.270.01(b) QMRP Refer to W159	
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	MM729 16.03.11 270 01(d) Treatment Plan Objectives Refer to W227	
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W231.	MM731	MM731 16.03.11.270.01(d)(ii) Measurable Behavioral Terms Refer to W231	
MM735	16.03.11.270.02 Health Services	MM735	MM735 16.03.11.270.02 Health Services Refer to W322	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM735	Continued From page 4 The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	MM753 16.03.11.270.02(f)(i) Locked Area Refer to W382 MM821 16.03.11.270.06(b)(i)(a) Evaluation and Screening Refer to W220 MM836 16.03.11.270.07 Physical and Occupational Therapy Services Refer to W218	
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753		
MM821	16.03.11.270.06(b)(i)(a) Evaluation and Screening Evaluation and screening of residents' speech and hearing functions This Rule is not met as evidenced by: Refer to W220.	MM821		
MM836	16.03.11.270.07 Physical and Occupational Therapy Services Physical and Occupational Therapy Services. Physical and occupational therapy services must be made available to any resident in need of such treatment. This Rule is not met as evidenced by: Refer to W218.	MM836		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM836	Continued From page 5	MM836		
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W260.	MM861	MM861 16.03.11.270.08(f)(iii) Periodic Review Refer to W260	

09/15/09

The following is an addendum to my original POC, from the July 16th, 2009 Cornerstone Survey.

W 112 483.410(c)(2) CLIENT RECORDS

The facility has ordered cubicals to be placed at the Day Treatment Center for the clients privacy, they cubicals have been ordered thru The School Outfitters and are to arrive on October 15th, 2009.

W 488 483.480(d)(4)
DINING AREA AND SERVICES

Two dining room tables will be moved from Courtyard to Cornerstone on November 1st, 2009, at which time family style dining will begin. The delay in the process is due to having to purchase two new tables in order to move tables.

Teresa Carpenter
Teresa Carpenter
Administrator